IN THE STATE COURT OF ATHENS-CLARKE COUNTY
STATE OF GEORGIA

TRUONG VANG Individually and as Administrator of the Estate of KANG MOUA, deceased,	)	CIVIL ACTION
Plaintiff,	)	FILE NO. _____
— *versus* —	)	
ST. MARY'S HEALTH CARE SYSTEM, INC.	)	JURY TRIAL DEMANDED
ATHENS-CLARKE EMERGENCY SPECIALISTS, P.C.	)	
TROY E JOHNSON, M.D., P.C.	)	
TROY E. JOHNSON, MD	)	
JOHN/JANE DOE 1-10,	)	
Defendants	)	

PLAINTIFF'S COMPLAINT FOR DAMAGES

Nature of the Action

1. This medical malpractice, wrongful-death action arises out of medical services negligently performed on Kang Moua on August 10, 2019.

2. Plaintiff Troung Vang is the husband of Kang Moua, deceased.

3. At the time of her death, Kang Moua was 38 years old with a life expectancy of an additional 44 years.[1]

4. Kang was survived by her husband and their two daughters.

5. As Adminstrator, Plaintiff Troung Vang asserts a claim on behalf of the estate of Kang Moua for harm she suffered before she died.

6. Plaintiff also asserts a wrongful-death claim pursuant to OCGA Title 51, Chapter 4.

7. Pursuant to OCGA § 9-11-9.1, the Affidavit of Peter Mowschenson, MD, and the Affidavit of Judith Climenson, RN are attached hereto as Exhibits 1 and 2.

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[1] *See* National Vital Statistics Reports, Vol. 68, No. 7, June 24, 2019, Table 3. Life table for females: United States, 2017, available at https://www.cdc.gov/nchs/data/nvsr/nvsr68/nvsr68_07-508.pdf.

This Complaint incorporates the opinions and factual allegations contained in those affidavits.

8. As used in this Complaint, the phrase "standard of care" means that degree of care and skill ordinarily employed by the medical profession generally under similar conditions and like circumstances as pertained to the Defendant's actions under discussion.

Parties, Jurisdiction, and Venue

9. **The Administrator of the Estate of Kang Moua** (for purposes of jurisdiction) is a citizen of Georgia. At the time of her death, Kang Moua was a citizen of Georgia. Pursuant to 28 USC 1332(c), therefore, the Administrator of her estate is a citizen of Georgia.[2]

10. **Truong Vang** is now a citizen of California, where he lives with his and Kang Moua's two daughters. Truong submits to the jurisdiction and venue of this Court.

11. **Defendant St. Mary's Health Care System, Inc. ("SMH")** is a Georgia corporation with its Registered Office in Athens-Clarke County. SMH may be served through their Registered Agent, D. Montez Carter, at 1230 Baxter Street, Athens, Georgia 30606.

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[2] "For the purposes of this section and section 1441 of this title … (2) the legal representative of the estate of a decedent shall be deemed to be a citizen only of the same State as the decedent…."

12. Pursuant to OCGA §§ 14-2-510 and 14-3-510,[3] SMH is subject to venue in this Court because (a) it maintains its registered office in Athens-Clarke County and (b) the cause of action originated in Athens-Clarke County and the corporation has an office and transacts business in that county.

13. Plaintiff believes that at all relevant times, SMH was the employer of the nurses and resident whose conduct is at issue in this lawsuit. However, if any other entity was the principal of the nurses and resident whose conduct is at issue, each such entity is hereby on notice that but for a mistake concerning the identity of the proper party, the action would have been brought against it.

14. SMH has been properly served with this Complaint.

15. SMH has no defense to this lawsuit based on undue delay in bringing suit — whether based on the statute of limitations, the statute of repose, laches, or any similar theory.

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[3] OCGA §§ 14-2-510 and 14-3-510 provide identical venue provisions for regular business corporations and for nonprofit corporations:

> "Each domestic corporation and each foreign corporation authorized to transact business in this state shall be deemed to reside and to be subject to venue as follows: (1) In civil proceedings generally, in the county of this state where the corporation maintains its registered office.… (3) In actions for damages because of torts, wrong, or injury done, in the county where the cause of action originated, if the corporation has an office and transacts business in that county; (4) In actions for damages because of torts, wrong, or injury done, in the county where the cause of action originated."

Note: These same venue provisions apply to Professional Corporations, because PCs are organized under the general "Business Corporation" provisions of the Georgia Code. *See* OCGA § 14-7-3. These venue provisions also apply to Limited Liability Companies, *see* OCGA § 14-11-1108, and to foreign limited liability partnerships, *see* OCGA § 14-8-46.

16. **Defendant Athens-Clarke Emergency Specialists, P.C. ("ACES")** is a Georgia professional corporation with its Registered Office in Athens-Clarke County. ACES may be served through their Registered Agent, Neil Allan Priest, at 1230 Baxter Street, Athens, Georgia 30606.

17. Pursuant to OCGA 14-2-510 and OCGA 14-7-2 and -3,[4] ACES is subject to venue in this Court because (a) it maintains its registered office in Athens-Clarke County and (b) the cause of action originated in Athens-Clarke County and the corporation has an office and transacts business in that county.

18. Plaintiff believes that at all relevant times, ACES was the employer of the Emergency Department physician whose conduct is at issue in this lawsuit (whom we believe to be Defendant Troy E. Johnson). However, if any other entity was the principal of the ED physician, each such entity is hereby on notice that but for a mistake concerning the identity of the proper party, the action would have been brought against it.

19. ACES has been properly served with this Complaint.

20. ACES has no defense to this lawsuit based on undue delay in bringing suit — whether based on the statute of limitations, the statute of repose, laches, or any similar theory.

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[4] Defining a "professional corporation" as a corporation organized under OCGA Title 14, Chapter 2 (and thus subject to OCGA 14-2-510).

21. **Defendant Troy E Johnson, M.D., P.C. ("PC")** is a Georgia professional corporation with its Registered Office in Lumpkin County. It may be served through its Registered Agent, Joe H. Gailey at 52 Clay Creek Overlook, Dahlonega, GA 30533.

22. Pursuant to OCGA 9-10-31, PC is subject to venue in this Court because its co-defendant, ACES, is subject to venue in this Court.[5]

23. Plaintiff believes that at all relevant times, PC was a principal of Defendant Troy E. Johnson. However, if any other entity was the principal of Dr. Johnson, each such entity is hereby on notice that but for a mistake concerning the identity of the proper party, the action would have been brought against it.

24. PC has been properly served with this Complaint.

25. PC has no defense to this lawsuit based on undue delay in bringing suit — whether based on the statute of limitations, the statute of repose, laches, or any similar theory.

26. **Defendant Troy E. Johnson, MD,** is a citizen of Georgia, residing in Oconee County. He may be served with process at his residence: 4091 Price Mill Road, Bishop, Georgia 30621.

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[5] "Subject to the provisions of Code Section 9-10-31.1 [regarding *forum non conveniens*], joint tort-feasors, obligors, or promisors, or joint contractors or copartners, residing in different counties, may be subject to an action as such in the same action in any county in which one or more of the defendants reside."

27. Pursuant to OCGA 9-10-31, Dr. Johnson is subject to venue in this Court because his co-defendant, ACES, is subject to venue in this Court.

28. At all times relevant to this Complaint, Dr. Johnson acted as an employee or agent of ACES.

29. At all times relevant to this Complaint, Dr. Johnson acted as an employee or agent of PC.

30. Dr. Johnson has been properly served with this Complaint.

31. Dr. Johnson has no defense to this lawsuit based on undue delay in bringing suit — whether based on the statute of limitations, the statute of repose, laches, or any similar theory.

32. **Defendants John/Jane Doe 1-10** are those yet unidentified individuals and/or entities who may be liable, in whole or part, for the damages alleged herein. Once served with process, John/Jane Doe 1-10 are subject to the jurisdiction and venue of this Court.

33. This Court has subject matter jurisdiction, and venue is proper as to all Defendants in this Court.

Facts

34. Kang Moua was a 38 year old otherwise healthy woman who underwent total thyroidectomy with neck dissection by Dr. Blake Kimbrell on 8/9/2019. The operation was performed for a diagnosis of papillary thyroid carcinoma which involved the left cervical lymph nodes.

35. Following an uncomplicated operation, Mrs. Moua was taken to the PACU where she remained stable, and then transferred to a regular floor to recover.

36. Pathology reports papillary thyroid carcinoma pT3 PN1b.

37. Postoperative bleeding following thyroidectomy is a well recognized, uncommon complication of the operation.

38. A postoperative hematoma in the neck is a potentially life-threatening emergency, because the hematoma may lead to compression and/or swelling of the trachea ("windpipe") and cut off the patient's air supply.

39. If a person goes without an air supply for more than a couple minutes, he or she may suffer permanent, catastrophic brain injury or death.

40. In the event of an evolving, postoperative hematoma in the neck that is threatening the airway, the sutures must be removed in an effort to reduce the hematoma.

41. Removing the sutures usually provides immediate relief to the patient and restores the airway.

42. Removing the sutures is a fundamental step in this situation and does not require any special surgical skills. Medical students, surgical residents, anesthesiologists, and emergency room physicians are all taught the importance of removing sutures in this situation.

43. Hospital nurses are trained to remove skin sutures, and routinely do so.

44. Immediate evacuation of the hematoma at the bedside in a patient with rapidly progressing airway compromise from a hematoma is an essential step in saving the patient's life.

45. In a patient who appears to have a rapidly progressing hematoma in the neck, it would be grossly negligent not to decompress the swollen wound immediately, by removing the sutures on the neck.

46. After her thyroidectomy, at approximately 0245 on 8/10/19, Mrs. Moua was helped to the bathroom by her husband and on returning, she complained of swelling in her left neck. Her husband alerted nursing.

47. At 0251 Mrs. Moua was noted to be unable to breathe.

48. A Code Blue was called.

49. A nurse from St. Mary's fifth surgical floor called Dr. Byron Norris, the ENT physician who was on call.

50. According to Dr. Norris' note, he ordered the neck sutures to be removed and drove to the hospital.

51. Fifth-floor staff also called down to the emergency room, for the assistance of the on-duty ER physician.

52. Dr. Troy E. Johnson was the ER physician on duty that night.

53. Dr. Johnson came up to the fifth floor to treat Kang Moua.

54. The standard of care required the nurse who spoke to Dr. Norris either personally to remove the sutures on Mrs. Moua's neck or, if a physician were present, to pass along Dr. Norris' instruction to remove the sutures.

55. On information and belief, the nurse did not do so. The nurse thereby violated the standard of care.

56. Dr. Johnson did not remove the sutures from Mrs. Moua's neck. Dr. Johnson thereby violated the standard of care.

57. Dr. Johnson did not decompress the hematoma in Mrs. Moua's neck.

58. Dr. Johnson attempted to perform an intubation but was unable to secure the airway.

59. Mrs. Moua went into cardiopulmonary arrest.

60. Dr. Norris arrived on the scene, removed the sutures, allowing the hematoma to decompress, and was then able to control Mrs. Moua's airway with an emergency tracheotomy.

61. Dr. Kimbrell arrived on the scene shortly after Dr. Norris.

62. Mrs. Moua was taken emergently to the operating room, where Dr. Kimbrell and Dr. Norris completed evacuation of the neck hematoma and identified some bleeding sites which were controlled.

63. Mrs. Moua was then transferred to the ICU.

64. Mrs. Moua suffered anoxic brain damage and died.

65. Autopsy revealed signs of the hematoma, but no other pathology which could have accounted for her death. In particular, Mrs. Moua had only mild coronary artery disease, supporting the impression that she was otherwise healthy.

66. Kang Moua's death was avoidable.

67. Pathology reports papillary thyroid carcinoma pT3 PN1b. Mrs. Moua would have subsequently been treated with radioactive iodine treatment and would have had an excellent prognosis.

68. Absent the mismanagement of the post-operative hematoma, more likely than not, Mrs. Moua would have lived a normal life span.

Count 1 – Injuries & Wrongful Death from Professional Negligence — SMH

69. Plaintiff incorporates by reference, as if fully set forth herein, all preceding paragraphs of this Complaint.

70. The standard of care required the nurse who spoke to Dr. Norris either personally to remove the sutures on Kang Moua's neck or, if a physician was present, to pass along to the physician the instruction to remove the sutures.

71. On information and belief, the nurse violated that standard of care.

72. That violation substantially contributed to the harm that befell Kang Moua.

73. On information and belief, the nurse was an employee of SMH.

74. SMH is vicariously liable for the negligence of the nurse, because he or she was acting within the scope of his or her agency for SMH.

75. Mrs. Moua's estate is entitled to recover from SMH for the physical, emotional, and economic injuries Mrs. Moua suffered before she died, including special damages such as funeral costs and other direct financial costs, as a proximate result of the Defendants' negligence.

76. Pursuant to OCGA Title 51, Chapter 4, Kang Moua's wrongful death beneficiaries are entitled to recover from SMH for the value of Mrs. Moua's life lost as a proximate result of the Defendants' negligence.

Count 2 – Injuries & Wrongful Death from Professional Negligence — ACES, PC, Johnson

77. Plaintiff incorporates by reference, as if fully set forth herein, all preceding paragraphs of this Complaint.

78. The standard of care required Dr. Johnson to remove the sutures from Kang Moua's neck immediately on seeing that a hematoma threatened Kang's airway.

79. Dr. Johnson did not remove the sutures.

80. Dr. Johnson violated the standard of care.

81. Dr. Johnson's violation of the standard of care caused Kang Moua to lose her airway and to suffer anoxic brain injury that led to Kang's death.

82. Dr. Johnson is directly liable for his own negligence.

83. ACES is vicariously liable for the negligence of Dr. Johnson, because he was acting within the scope of his employment with, or agency for, ACES.

84. PC is vicariously liable for the negligence of Dr. Johnson, because he was acting within the scope of his employment with, or agency for, PC.

85. Mrs. Moua's estate is entitled to recover from ACES, PC, and Dr. Johnson for the physical, emotional, and economic injuries, including special

damages such as funeral costs and other direct financial costs, that Mrs. Moua suffered before she died, as a proximate result of the Defendants' negligence.

86. Pursuant to OCGA Title 51, Chapter 4, Kang Moua's wrongful death beneficiaries are entitled to recover from ACES, PC, and Dr. Johnson for the value of Mrs. Moua's life lost as a proximate result of the Defendants' negligence.

Damages

87. Plaintiff incorporates by reference, as if fully set forth herein, all preceding paragraphs of this Complaint.

88. As a direct and proximate result of the Defendants' conduct, Plaintiff is entitled to recover from Defendants reasonable compensatory damages in an amount exceeding $10,000.00 to be determined by a fair and impartial jury for all damages Plaintiff suffered, including physical, emotional, and economic injuries.

89. WHEREFORE, Plaintiff demands a trial by jury and judgment against the Defendants as follows:

a. Compensatory damages in an amount exceeding $10,000.00 to be determined by a fair and impartial jury;

b. All costs of this action; and

c. Such other and further relief as the Court deems just and proper.

May 11, 2020

Respectfully submitted,

/s/ Lloyd N. Bell

Georgia Bar No. 048800
Daniel E. Holloway
Georgia Bar No. 658026

BELL LAW FIRM
1201 Peachtree St. N.E., Suite 2000
Atlanta, GA 30361
(404) 249-6767 (tel)
bell@BellLawFirm.com
dan@BellLawFirm.com

Attorneys for Plaintiff

AFFIDAVIT OF PETER M. MOWSCHENSON, MD REGARDING PROFESSIONAL NEGLIGENCE BY "ER DOCTOR JOHNSON"

PERSONALLY APPEARS before the undersigned authority, duly authorized to administer oaths, comes Peter M. Mowschenson, MD, who after first being duly sworn, states as follows:

Introduction and Limited Purpose of Affidavit

1. I have been asked to provide this affidavit for the limited purpose of Georgia statute OCGA § 9-11-9.1.

2. This affidavit states my views of the matters discussed below — views I formed from my review of the evidence. However, Plaintiff's counsel supplied the snapshots from medical records, the Bates numbers, the legalese, the formatting, etc.. The substance of the affidavit is mine.

3. This affidavit does not attempt to state or summarize all my opinions. This affidavit addresses specific matters that Plaintiff's counsel have asked me to examine for purposes of testimony at trial. I have not attempted to identify every person who may have violated a standard of care. Nor have I attempted to identify every standard of care that a particular person violated. If additional information becomes available later, then of course my opinions may change.

4. As to the matters this affidavit addresses, I have tried to give a reasonably detailed explanation of my views, but I have not necessarily attempted an exhaustive discussion. In deposition or trial testimony, I may elaborate with additional details. In particular, while I cite evidence from the medical records for various facts, I do not necessarily cite *all* the evidence for a given point.

5. I use the term "standard of care" to refer to that degree of care and skill ordinarily exercised by members of the medical profession generally under the same

or similar circumstances and like surrounding conditions as pertained to the medical providers I discuss here.

6. I hold all the opinions expressed below to a reasonable degree of medical certainty — that is, more likely than not.

Topic & Opinions

7. This affidavit concerns medical services provided to Kang Mŏua in August 2019, by "ER Doctor Johnson." The medical records do not identify Dr. Johnson by first name. I leave it to Plaintiff's counsel to further identify Dr. Johnson.

8. More specifically, this affidavit concerns the standards for a physician (a) generally, responding to a post-operative hematoma in the neck of a patient who recently underwent a thyroidectomy and (b) more specifically, acting on instructions from a surgeon telling the physician how to respond to the hematoma.

9. Dr. Johnson violated his standards of care as follows:

   a. Dr. Johnson failed to act on his own initiative to remove sutures in Kang Moua's neck upon seeing that a large hematoma was forming that threatened to block Mrs. Moua's airway and cause her profound injury.

   b. After receiving instructions from the on-call surgeon to remove the sutures, Dr. Johnson nonetheless failed to remove them.

10. These were gross violations of the standard of care.

11. These standard-of-care violations caused injury to Mrs. Moua.

Qualifications

12. I am more than 18 years old, suffer from no legal disabilities, and give this affidavit based upon my own personal knowledge and belief.

13. I do not recite my full qualifications here. I recite them only to the extent necessary to establish my qualifications for purposes of expert testimony under OCGA 24-7-702.

14. However, my Curriculum Vitae is attached hereto as Exhibit "A." My CV provides further detail about my qualifications. I incorporate and rely on that additional information here.

15. The acts or omissions at issue here occurred in August 2019.

16. I am qualified to provide expert testimony pursuant to OCGA 24-7-702. That is:

a. In August 2019, I was licensed by an appropriate regulatory agency to practice my profession in the state in which I was practicing or teaching in the profession.

   Specifically, I was licensed by the State of Massachusetts to practice medicine. That's where I was practicing medicine in August 2019.

b. In August 2019, I had actual professional knowledge and experience in the area of practice or specialty which my opinions relate to — specifically, the areas of:

   - Responding to a rapidly growing post-operative hematoma in the neck, which threatens to obstruct the patient's airway.

   - Acting on a consulting surgeon's instruction to remove sutures in the neck of a patient with a rapidly growing post-operative hematoma.

c. I had this knowledge and experience as the result of having been regularly engaged in the active practice of the foregoing areas of specialty of my profession for at least three of the five years prior to August 2019, with sufficient frequency to establish an appropriate level of knowledge of the matter my opinions address.

Specifically, I am a board-certified surgeon in a teaching hospital and for years have practiced and taught medical residents in the care of patients after surgery, including the handling of post-operative hematomas in the neck.

Evidence Reviewed

17. I have reviewed Kang Moua's medical records from St. Mary's Health Care System and the autopsy report from Forensic Medicine Associates, Inc.

Discussion and Factual Basis for Opinions

Narrative

18. Moua Kang was a 38 year old otherwise healthy woman who underwent total thyroidectomy with neck dissection by Dr. Blake Kimbrell on 8/9/2019. The operation was performed for a diagnosis of papillary thyroid carcinoma which involved the left cervical lymph nodes. (SMH 31-34.)

DATE OF OPERATION: 08/09/2019

PREOPERATIVE DIAGNOSIS:
T3N1bMx papillary thyroid carcinoma of the left thyroid.

POSTOPERATIVE DIAGNOSIS:
T3N1bMx papillary thyroid carcinoma of the left thyroid.

PROCEDURE PERFORMED:
1. **Total thyroidectomy with recurrent laryngeal nerve monitoring.**
2. **Left selective neck dissection levels 2 through 4.**
3. **Left central neck dissection.**

SURGEON:
Blake Kimbrell, M.D.

19. Following an uncomplicated operation, Moua Kang was taken to the PACU where she remained stable, and then transferred to a regular floor to recover. (SMH 34.)

nylon was used at the skin followed by bacitracin. The patient tolerated the procedure well and was given back to anesthesia, awakened, extubated, and taken to the PACU in stable condition.

20. Pathology reports papillary thyroid carcinoma pT3 PN1b. (SMH 30.)

RUN DATE: 08/20/19 St. Mary's Healthcare System LAB *LIVE* PAGE 2
RUN TIME: 0001 ARCHIVAL PATH REPORT

SPEC: S19-6210 PATIENT: MOUA,KANG AC0002176029 (Continued)

FINAL DIAGNOSIS (Continued)

Level 6 pretracheal lymph nodes:
1. Metastatic papillary carcinoma involving one of approximately five lymph nodes (1/5).
2. Attached portion of benign thymic tissue and normal parathyroid gland.

JJG/wv

COMMENT

This lesion would stage as a pT3 pN1b lesion.

21. At 0245 on 8/10/19, Moua Kang was helped to the bathroom by her husband and on returning she complained of swelling in her left neck. Her husband alerted nursing. (SMH 14, 500.)

This is a 38-year-old Asian female the past medical history of papillary thyroid cancer came in for thyroidectomy that was performed yesterday on 8/9/2018. After surgery, the patient was reported to be stable and doing well. Around 2:45 AM on 8/10/she ambulated to the bathroom 2019 and after she laid down she was found by the nurse to having stridorous. CODE BLUE was called at 2:51 AM. CODE BLUE was called at 2:51 AM. Patient was found to be cyanotic and chest compression immediately began at 2:52 AM. During my encounter, there was noted hematoma localized to the left anterior neck region with staples intact. Manual chest compression was substituted via Lucas device compression. Overall patient received 4 doses of IV epinephrine and patient was in PEA. ER physician Dr. Johnson attempted to place an endotracheal tube but due to the neck hematoma he was unable to secure her airway. Dr. Norris the ENT physician came in and instructed to remove the staples with creating an incision to prepare for placement for tracheostomy. Blood was being suctioned and then patient was in process of being transferred to the OR. Prior to leaving the room patient still did not have ROSC and was still receiving LUCAS device compressions. ET tube was placed through the incised trach site prior to leaving the room. While receiving compressions in the OR, the defibrillator device showed her to be in V. fib briefly. Patient received a shock

Occurred		Recorded			Notes: All Categories
Date	Time	Date	Time	By	Category
08/10/19	0251	08/10/19	0609	SAM	Nurse

Patient husband calls for help with another nurse in room. He was apparently getting her back into bed from walking to the bathroom. Upon entering room, patient had a visible hematoma that was not present approximately 1.5 hours earlier. She was in respiratory distress and was given additional o2. Her color began to become more pale and a code blue was called to begin resuscitation as the patient had stopped breathing on her own by this time.

22. At 0251 Moua Kang was noted to be unable to breathe. A Code Blue was called. The nurses called Dr. Norris of ENT who was on call. He drove into the hospital and according to his note ordered the neck sutures to be removed. (SMH 14, 215, 216, 500.)

[*See* screenshots above.]

I was called by the St. Mary's fifth surgical floor at 2:56 a.m. regarding the patient. The personnel reported that the patient was undergoing a code and that the code team was unable to establish an airway. I made a recommendation to cut the patient's thyroidectomy sutures to remove her drains and to call both Anesthesia and General Surgery if General Surgery was in house. I proceed immediately to the bedside. En route to the hospital, I called Dr. Blake Kimbrell to notify him of the events. Upon arrival to the bedside, I asked for a tracheostomy tray. I immediately removed the anterior cervical sutures which had not been cut and evacuated the hematoma of the anterior cervical area. The airway was deviated into the right neck but was not compressed as I could tell from palpation. I cut the sutures of the strap musculature and established an airway with a 6.0 cuffed endotracheal tube. There was a hematoma in the left neck and pressure was applied to prevent any further bleeding. The code was ongoing and Anesthesia was then at the bedside as was Dr. Kimbrell. We proceeded down to the operating room for surgery.

23. Dr. Johnson, an emergency room physician was called and attempted to intubate the patient. He did not remove the sutures as requested by Dr. Norris and he was unable to perform the intubation. The patient then went into cardiopulmonary arrest. (SMH 14, 216.)

This is a 38-year-old Asian female the past medical history of papillary thyroid cancer came in for thyroidectomy that was performed yesterday on 8/9/2018. After surgery, the patient was reported to be stable and doing well. Around 2:45 AM on 8/10/she ambulated to the bathroom 2019 and after she laid down she was found by the nurse to having stridorous. CODE BLUE was called at 2:51 AM. CODE BLUE was called at 2:51 AM. Patient was found to be cyanotic and chest compression immediately began at 2:52 AM. During my encounter, there was noted hematoma localized to the left anterior neck region with staples intact. Manual chest compression was substituted via Lucas device compression. Overall patient received 4 doses of IV epinephrine and patient was in PEA. ER physician Dr. Johnson attempted to place an endotracheal tube but due to the neck hematoma he was unable to secure her airway. Dr. Norris the ENT physician came in and instructed to remove the staples with creating an incision to prepare for placement for tracheostomy. Blood was being suctioned and then patient was in process of being transferred to the OR. Prior to leaving the room patient still did not have ROSC and was still receiving LUCAS device

Brief progress note was entered (just as patient was transferred from the OR to her ICU room). Since, I have met with the family (at the appropriate time, discussed with Troung, her husband), discussed the event with nursing, and performed a chart review to better understand the timeline of events. Her husband reports she was doing well throughout the evening. He recalls RN checking on her between 1 and 2 am. He reports he went back to sleep but everything appeared to be well. Just before he called for nursing, he took Mrs. Moua to the restroom at her request. He confirmed to me at that time and throughout her restroom trip there were no complaints of increased pain, difficulty breathing or swallowing. In fact, she even requested to brush her teeth prior to getting back in bed (he wouldnt let her and told her she needed to rest). He reports she was "fine" even as she sat back down. Then, she "leaned her head back" reported a "pop" and started to complain of pain in the neck. He noted swelling at that time and called nursing immediately. Floor nursing called the rapid response and code. Unfortunately, Dr. Norris' request of cutting sutures in the neck weren't done when he had arrived. Oral intubation could not be obtained. He was able to immediately evacuate the clot after cutting sutures and a trach was quickly performed (her airway was easily palpable following the removal of her cancer). The remainder of the details are documented in Meditech.

24. Manual chest compression was employed at 0251 according to the Code Blue Flowsheet. (SMH 496.)

Time	Breathing		Pulse		BP
	Spontaneous	Assisted (✓)	Spontaneous	Assisted (✓)	
0251		✓		✓	

25. Dr. Norris arrived on the scene, promptly removed the sutures which allowed the hematoma to decompress, and was then able to control the patient's airway with an emergency tracheotomy. Intubation through the emergency tracheotomy site was recorded as 0310 with a 6.5 tube. (SMH 13-14, 48, 215-16, 500.)

[*See* screenshots above.]

> CODE BLUE was called at 2:51 AM. Patient was found to be cyanotic and chest compression immediately began at 2:52 AM. During my encounter, there was noted hematoma localized to the left anterior neck region with staples intact. Manual chest compression was substituted via Lucas device compression. Overall patient received 4 doses of IV epinephrine and patient was in PEA. ER physician Dr. Johnson attempted to place an endotracheal tube but due to the neck hematoma he was unable to secure her airway. Dr. North the ENT physician came in and instructed to remove the staples with creating an incision to prepare for placement for tracheostomy. Blood was being suctioned and then patient was in process of being transferred to the OR. Prior to leaving the room patient still did not have ROSC and was still receiving LUCAS device compressions. ET tube was placed through the incised trach site prior to leaving the room

26. The code flowsheet lists Teonna Greggs RN as the recorder, Christie as the ICU code team nurse, Heather Hust RN as the ER nurse, and Tori Hall RRT as the respiratory therapist. The sheet is signed by a physician whose signature I cannot read but I suspect it is Dr. Johnson. (SMH 496.)

Signatures

Recorder Teonna Greggs, RN ID# 425836
ICU/Code Team Nurse Christie ID#
Emergency Dept. Nurse Heather Hust, RN ID#
Respiratory Therapist Tori Hall, RT ID#
Physician Signature
Other Title

27. There is then a follow up note regarding the Code Blue signed by Waqas Ahmad MD, a resident, which mentions 0245 as the time the patient began to have significant breathing problems. (SMH 48.)

> The nurse reported patient clinically was doing well prior to the CODE BLUE. Apparently she was ambulating to the restroom around 2 45 AM and when she layed down patient respiratory status worsened as the nursed noted her to have stridor. RAPID RESPONSE was called but this was escalated immediately to CODE BLUE.

28. There is a handwritten progress note by Dr. Kimbrell at 0451 and then 055? stating that he was first called at 0256 and informed of the code and the uncontrolled airway. The note is slightly contradictory in that the first paragraph states that he obtained the airway as soon as he arrived, but in the third paragraph he states that the airway had already been established by the time he arrived. (SMH 264.)

8/10/19	ENT
0451	See full note dictated.
	I was called at 0256 by the 5th floor who reported that Ms. Kang was in a code situation and did not have an airway. I came immediately and was able to establish the airway by removing the anterior cervical sutures, the sutures to the strap musculature, and by creating a tracheostomy and placement of a 6.0 cuffed ETT.
	While continuing code management, we proceeded to the OR & anesthesia and pulses were reestablished and a wash out of the neck performed. There was bleeding from the left superior thyroid artery despite a surgical clip in place in good position. There was some oozing from clips on the left internal jugular vein which was ligated. The tracheostomy was formalized and a 6 DCT trach placed. The patient was transferred to the ICU.
8/10/19	I have been present since 0310 helping care for Ms. Moua. When I arrived
055	the airway had been established. I immediately went to the OR & Dr. Norris to examine her neck for bleeding. Please see my dictation for details. All vessels were identified and clipped. Once clot was removed the left superior thyroid artery clip was moved slightly and the artery was bleeding. I have updated the family and will continue to be here for them, following closely.

29. Moua Kang was taken emergently to the OR where Dr. Kimbrell and Dr. Norris completed evacuation of the neck hematoma and identified some bleeding sites which were controlled. (SMH 37.)

DATE OF OPERATION: 08/10/2019

SURGEON:
Blake Kimbrell, MD

CO-SURGEON:
Byron Norris, MD

ANESTHESIA:
General via tracheostomy placement.

OPERATION PERFORMED:
1. Washout of left neck hematoma.
2. Revision of tracheostomy tube placement.
3. Control of left neck bleeding.

PREOPERATIVE DIAGNOSES:
1. Cervical hematoma.
2. Respiratory distress.
3. Bleeding of the left neck.

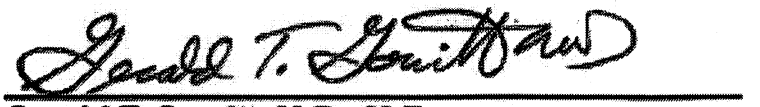
30. Moua Kang was then transferred to the ICU. She suffered anoxic brain damage and died. (SMH 25.)

> Although the patient's temperature was at the lower end of the range reported for valid brain death examination, I believe that due to the very dilute urine output and the patient's exam, the patient's status is worrisome for being consistent with brain death. We will warm the patient and I have consulted both Dr. Edry and also spoken with Dr. Bhatt regarding making the patient more normothermic prior to formal brain death confirmatory examination. However, 33 degrees Celsius has generally been reported as acceptable in the range of the peer-reviewed literature. In addition to that, the patient's CT scanning certainly is a very impressive in terms of the progression of cerebral edema. I have discussed the findings and full with multiple family members and they were understandably very upset by this development. I informed them that independent physicians would be coming in to examine Ms. Moua and also provide further confirmation of her neurological status. I also discussed the findings with both Dr. Norris and Dr. Kimbrell.

31. Autopsy revealed signs of the hematoma, but no other pathology which could have accounted for her death. In particular, Mrs. Kang had only mild coronary artery disease, supporting the impression that she was otherwise healthy. (FMA 12.)

It is the opinion of the undersigned that Ms. Moua died as a result of ischemic/hypoxic encephalopathy due to cardiorespiratory arrest precipitated by an expanding left neck hematoma.

No other reasonable explanation for her cardiorespiratory arrest on August 10th was found in the clinical record or the autopsy.



Gerald T. Gowitt, M.D., M.E.
Kh08202019

32. There is an additional progress note by Dr. Kimbrell at 0846 on 8/10/19 in which he states that Dr. Norris' request of cutting sutures had not been carried out when he arrived. (SMH 216.)

[*See* screenshot above.]

33. There is also a progress note by Dr. Norris at 0554 on 9/10/19. He states that he was called at 2:56 AM and that he recommended removing the neck sutures. He states that upon opening the neck the trachea was deviated to the right 'but not compressed.' He was able to control the airway. (SMH 215.)

[*See* screenshot above.]

Discussion

34. This is a tragic case, and Moua Kang's death was avoidable. Postoperative bleeding following thyroidectomy is a well recognized uncommon complication of the operation and can occur in the best of hands. The thyroidectomy was indicated, consent was obtained, and the operation was conducted correctly.

35. The operative note was dictated on the day of surgery and is detailed and complete. The postoperative orders were appropriate. Transfer from the PACU to a regular floor was appropriate.

36. Pathology reports papillary thyroid carcinoma pT3 PN1b. The patient would have subsequently been treated with radioactive iodine treatment and would have had an excellent prognosis. More likely than not, Mrs. Kang would have lived a normal life span.

37. As soon as the patient's husband alerted the nursing staff, attempts were made to manage this situation. Dr. Johnson, an ER physician, was called, and he attempted to obtain an airway, which was an essential step in saving Mrs. Kang's life. At the same time Dr. Norris, the covering ENT that night, was contacted. He issued instructions to remove the patient's sutures in order to facilitate airway control. This was an essential and appropriate request.

38. However, this request was not carried out. The notes are incomplete in this respect. I do not know who Dr. Norris spoke to, or if that request was then passed on to Dr. Johnson. Regardless, as an ER physician, Dr. Johnson should have known that decompression of a post-operative hematoma by removing the sutures is always the first step in controlling the airway in a patient whose airway is becoming increasingly threatened.

39. In fact, removing the sutures and allowing the hematoma to self-evacuate usually provides immediate relief to the patient and avoids the need for a tracheotomy.

40. Removing the sutures is a fundamental step in this situation and does not require any special surgical skills. Medical students, surgical residents, anesthesiologists, and emergency room physicians are all taught the importance of removing sutures in this situation. It was grossly negligent not to decompress the swollen wound immediately.

41. Dr. Johnson was presented with a patient whose airway was severely compromised and becoming more short of breath. If Dr. Johnson had started by removing the sutures, or had removed them as soon as he saw that intubation via the mouth was not feasible, more likely than not Mrs. Kang would have been able to start breathing on her own again and would not have suffered anoxic brain damage.

42. Dr. Norris noted that when he opened the incision and felt the trachea, it was deviated to the right but not compressed. Deviation to the right would be expected because the hematoma was pushing it over from the left side.

43. However, I disagree with Dr. Norris' assessment of compression. The trachea is made up of cartilaginous rings on the front and the sides. Cartilage is rigid and for practical purposes cannot be compressed without fracturing the rings. The posterior wall of the trachea, however, is very soft. The posterior wall is called the membranous trachea. That soft posterior wall lies against the esophagus. When a hematoma forms in the neck, it puts pressure on the trachea, and it becomes narrow because the membranous trachea is pushed inwards by the pressure, narrowing the opening of the trachea. That is why relieving the hematoma pressure by removing the sutures affords immediate benefit. The pressure on the membranous trachea immediately reduces, and the airway opens up again, allowing the patient to breathe.

44. Immediate evacuation of the hematoma at the bedside in a patient with increasing airway compromise from a hematoma is an essential step in saving the patient's life.

Miscellaneous

45. To repeat, this affidavit does not exhaust my current opinions and of course does not reflect any opinions I may form later.

46. Again, I hold each opinion expressed in this affidavit to a reasonable degree of medical probability or certainty; that is, more likely than not.

Peter M. Mowschenson, MD

SWORN TO AND SUBSCRIBED before me

March 20, 2020

NOTARY PUBLIC

My Commission Expires: 9/25/26

Curriculum Vitae

Date Prepared: 11/11/19

Name: Peter Michael Mowschenson

Office Address: 1180 Beacon St.
Brookline, MA 02446

Home Address: 1 Charles St. South, 15D
Boston, MA 02116

Work Phone: 617-735-8868

Work Email: pmowsche@caregroup.harvard.edu

Work FAX: 617-730-9845

Place of Birth: Penang, Malaya

Education

1969	B.Sc. (First Class Honours)	Guy's Hospital Medical School, University of London, England
1973	L.R.C.P., M.R.C.S.	
1973	M.B.,B.S. (First Class Honors)	
1975	M.R.C.P. (U.K.)	
1977	F.R.C.S. (Eng)	

Postdoctoral Training

1973-1975	Registrar	Surgery	Guy's Hospital, London
1975-1979	Resident	Surgery	Beth Israel Hospital
1979-1980	Surgical Coordinator		Beth Israel Hospital
1980-1982	Fellow	Endocrinology	Harvard School of Public Health

Faculty Academic Appointments

7/81-9/90	Clinical Instructor in Surgery	Harvard Medical School
1990-2016	Clinical Assistant Professor of Surgery	Harvard Medical School

2017	Assistant Professor of Surgery	Harvard Medical School

Appointments at Hospitals/Affiliated Institutions

1981-1987	Assistant Surgeon	Dept. of Surgery	Beth Israel Hospital
1987-1988	Associate Surgeon	Dept. of Surgery	Beth Israel Hospital
1989-	Surgeon	Dept. of Surgery	Beth Israel Hospital [after 1996: Beth Israel Deaconess Medical Center]

Major Administrative Leadership Positions

Local

1984-1988	Chief of Surgery, Brookline Hospital, Brookline, MA
1994-1997	Executive Board Member, Harvard Center for Minimally Invasive Surgery
1995- 2019	President, Affiliated Physicians Inc., Beth Israel Deaconess Medical Center [prior to 1996: Affiliated Physicians Inc., Beth Israel Hospital]
1996-2014	Vice President & Board Member, Beth Israel Deaconess Care Organization [prior to 2013: Beth Israel Deaconess Physicians Organization]
2001-2010	Member, Board of Trustees, Beth Israel Deaconess Medical Center
2014-Present	Board Member, Beth Israel Deaconess Care Organization

Committee Service

Local

1982-2000	Staff Council	Beth Israel Hospital
1988-2001	Medical Executive Committee	Beth Israel Hospital [after 1996: Beth Israel Deaconess Medical Center]

Professional Societies

1983-Present	American Association of Endocrine Surgeons	Member
1983-Present	American College of Surgeons	Fellow
1987-	Boston Surgical Society	Member

Present		
1981-Present	Massachusetts Medical Society	Member
1990-Present	Society Of Laparendoscopic Surgeons	Member
1990-Present	New England Surgical Society	Member
1990-Present	Society for Surgery of the Alimentary Tract	Member

Honors and Prizes

1968	Michael Harris Prize In Anatomy	Guy's Hospital Medical School
	Gowland Hopkins Prize In Biochemistry	Guy's Hospital Medical School
	Pharmacology Prize	Guy's Hospital Medical School
	University Award For Best Performance In 2nd M.B. Examination	Guy's Hospital Medical School
1970	Dermatology Prize	Guy's Hospital Medical School
1971	Charles Oldham Prize in Ophthalmology	Guy's Hospital Medical School
1972	Beaney Prize In Patholgy	Guy's Hospital Medical School
	Golding Bird Gold Medal and Scholarship in Bacteriology	Guy's Hospital Medical School
	Hillman Prize In Paediatrics	Guy's Hospital Medical School
	Hillman Prize In Haematology 1973	Guy's Hospital Medical School
	Charles Foster Prize In Cardiology	Guy's Hospital Medical School
	Begley Prize of The Royal College of Surgeons	The Royal College of Surgeons
	Honours in the Final M.B.,B.S. Examination in Medicine, Surgery, Pharmacology, Pathology	Guy's Hospital Medical School
	University Gold Medal - Top Performance in the final qualifying examination for M.B.,B.S.	Guy's Hospital Medical School
1975	Hallet Prize of The Royal College of Surgeons for Top Performance in the F.R.C.S Examination	The Royal College of Surgeons
1976	Harris Yett Prize In Orthopaedics	Beth Israel Hospital

1986	Harold Bengloff Award	Dept. of Surgery, Beth Israel Hospital	Teaching
2004	Harold Bengloff Award	Dept. of Surgery, Beth Israel Deaconess Medical Center	Teaching

Report of Local Teaching and Training

Teaching of Students in Courses

1981-present	*Introduction to Clinical Medicine* Surgical preceptor for Harvard Medical Students	Beth Israel Deaconess Medical Center [prior to 1996: Beth Israel Hospital] 2 hrs per week
2000-2013	"Surgery of Inflammatory Bowel Disease" *Core Clerkship in Surgery* 3rd year medical students	Beth Israel Deaconess Medical Center 1 hr lecture, 3-4 times/year

Formal Teaching of Residents, Clinical Fellows and Research Fellows (post-docs)

1988-1993	Text Review sessions for surgical residents. Weekly sessions for topic review and regular multiple choice question examination.	Beth Israel Hospital 4 hrs weekly

Clinical Supervisory and Training Responsibilities

1981-	*Core Clerkship in Surgery* 3rd year medical students Clinical teacher on rounds and in the OR	Beth Israel Deaconess Medical Center [prior to 1996: Beth Israel Hospital] 3-4 operative days; daily inpatient rounds
1981-	*Residency Program in General Surgery* PGY 1-5 Clinical teacher on rounds and in the OR	Beth Israel Deaconess Medical Center [prior to 1996: Beth Israel Hospital] 3-4 operative days; daily inpatient rounds

Formal Teaching of Peers (e.g., CME and other continuing education courses)

No presentations below were sponsored by outside entities.

1992- 2016	Mowschenson PM. Advances in the Medical And Surgical Treatment of Inflammatory Bowel Disease. Harvard Medical School Department of Continuing Education.	Boston, MA

Local Invited Presentations

No presentations below were sponsored by outside entities.

1983	Surgical Treatment of Hyperparathyroidism. Surgical Grand Rounds/Beth Israel Hospital, Boston, MA

1987	Management of substernal goiters. Primary Care rounds/Beth Israel Hospital, Boston, MA
1989	Controversies regarding Hyperparathyroidism. Surgical Grand Rounds/Beth Israel Hospital, Boston, MA
1990	Abdominal Pain. Medical Grand Rounds/Beth Israel Hospital, Boston, MA
1991	Surgical approach to thyroid disorders. Primary Care Rounds/Beth Israel Hospital, Boston, MA
1991	Current options in the surgery of ulcerative colitis. Anesthesia Grand Rounds/Beth Israel Hospital, Boston, MA
1992	Developments in ileoanal pouch surgery at Boston's Beth Israel Hospital. Surgical Grand Rounds/Beth Israel Hospital, Boston, MA
1993	The Ileoanal Pouch Operation: Controversies and Outcome. Surgical Grand Rounds/Brigham & Women's Hospital, Boston, MA
1994	Surgical advancements in the treatment of inflammatory bowel disease. Medical Grand Rounds/Beth Israel Hospital, Boston, MA
1995	Ileoanal pouch surgery. Surgical Grand Rounds/New England Deaconess Hospital , Boston, MA
1996	Surgical Management of Hyperparathyroidism. Surgical Grand Rounds/Mt. Auburn Hospital, Cambridge, MA
1997	Advances in the surgical treatment of inflammatory bowel disease. Postgraduate course/Beth Israel Deaconess Medical Center, Boston, MA
1999	Advances in the surgical treatment of inflammatory bowel disease. Postgraduate course/Beth Israel Deaconess Medical Center, Boston, MA
2000	Ten years of ileoanal pouch surgery. What lessons can be learned? Surgical Grand Rounds/Beth Israel Deaconess Medical Center, Boston, MA
2001	Current Surgical Treatment of Inflammatory Bowel Disease. Postgraduate course/Beth Israel Deaconess Medical Center, Boston, MA
2005	Instructor in Laparoscopic Colectomy. Postgraduate course/Beth Israel Deaconess Medical Center, Boston, MA
2014	Is our treatment of Hyperparathyroidism evidence based? Annual Pallotta Stevens Lecture: Beth Israel Deaconess Medical Center, Boston, MA
2014	Is our treatment of Hyperparathyroidism evidence based? Surgical Grand Rounds/Mount Auburn Hospital, Cambridge, MA

2015 Hyperparathyroidism. To Operate or Not. What is the evidence?
Surgical Grand Rounds/Beth Israel Deaconess Medical Center, Boston, MA

Report of Regional, National and International Invited Teaching and Presentations

Invited Presentations and Courses

No presentations below were sponsored by outside entities.

Regional

1984 Surgical Treatment of Hyperparathyroidism.
Surgical Grand Rounds/Salem Hospital, Salem, MA

1986 Surgical Treatment of Hyperparathyroidism.
Surgical Grand Rounds/Bay State Medical Center, Springfield, MA

1990 Controversies regarding Hyperparathyroidism
Medical Grand Rounds/Hale Hospital Haverhill MA

1991 Advances in ileoanal pouch surgery.
Surgical Grand Rounds/Bay State Medical Center, Springfield, MA

1991 Advances in ileoanal pouch surgery.
Surgical Grand Rounds/Salem Hospital, Salem, MA

1991 Advances in ileoanal pouch surgery.
Surgical Grand Rounds/St. Vincent's Hospital, Univ. of Massachusetts, Worcester, MA

1992 Advances in ileoanal pouch surgery.
Surgical Grand Rounds/Univ. of Massachusetts Medical Center, Worcester, MA

1992 Improving the cost effectiveness of laparoscopic cholecystectomy.
Massachusetts Chapter, American College of Surgeons

1992 Developments in ileoanal pouch surgery at Boston's Beth Israel Hospital.
Surgical Grand Rounds/Framingham Union Hospital, Framingham, MA.

1994 Management of the Rectum in ulcerative colitis.
Spring meeting Massachusetts Chapter, American College of Surgeons, Needham, MA

1994 Preservation of sexual and urinary function following ultralow rectal dissection for the ileoanal pouch operation.
New England Surgical Society

1995 Thyroid surgery - How I do it.
Massachusetts Chapter, American College of Surgeons

1998 New Strategies in IBD therapy.
Rhode Island Chapter, Crohn's and Colitis Foundation, Newport, RI

1999 Controversies in the treatment of ulcerative colitis.

New England Surgical Society Spring Meeting, Boston, MA

1999 Ileoanal Pouch Operation: Long Term Outcome With or Without Diverting Ileostomy.
New England Surgical Society Annual Meeting

2002 Controversies in inflammatory bowel disease.
New England Surgical Society Annual Meeting September 2002

2013 Advances in thyroid and parathyroid surgery.
St. Elizabeth's Medical Center, Boston, MA

National

1992 Developments in ileoanal pouch surgery at Boston's Beth Israel Hospital.
Buffalo Surgical Society, Buffalo, NY

1992 Advances in the Medical and Surgical Therapy of IBD.
Crohn's & Colitis Foundation of America, Inc.

1993 **Mowschenson PM,** Critchlow JF, Rosenberg SJ, Peppercorn MA. Ileoanal pouch operation without diverting ileostomy in fulminant ulcerative colitis.
American Gastroenterology Association, Boston, MA

1994 Crohn's and Colitis Foundation physician's seminar on surgical treatment of ulcerative colitis.

1994 **Mowschenson** PM, Hodin RA, Wang HH, Upton M, Silen W. Fine Needle Aspiration of Normal Thyroid Tissue May result In the Misdiagnosis of Follicular Neoplasms.
American Association of Endocrine Surgeons

1994 American Gastroenterology Association New Orleans Forum on Inflammatory Bowel Disease, New Orleans, LA

1994 **Mowschenson PM**, Critchlow JF. Outcome of surgical complications following ileoanal pouch operation without diverting ileostomy.
Society for Surgery of the Alimentary Tract, New Orleans, LA

1995 Surgical approaches to IBD during pregnancy - Inflammatory Bowel Disease Forum
American Gastroenterology Association, San Diego, CA

1995 Feasibility of outpatient thyroid and parathyroid operations.
American Association of Endocrine Surgeons

1996 Surgical Management of Crohn's disease. Crohn's and Colitis foundation

1999 Green A.K., **Mowschenson P**, Hodin RA. Is radioguided parathyroidectomy really cost-effective? American Association of Endocrine Surgeons, Yale, New Haven, CT

International

1999 Experience with outpatient thyroid and parathyoid surgery.

Retirement symposium for Professor the Lord McColl/Guy's Hospital, London

Report of Clinical Activities and Innovations

Current Licensure and Certification

1976	Massachusetts medical license
1980	Board certification in general surgery (Recertified in 1989, 2001, 2009)

Practice Activities

1981-	General Surgery (thyroid, parathyroid surgery)	Beth Israel Deaconess Medical Center [prior to 1996: Beth Israel Hospital]	3-4 operative days; daily inpatient rounds

Report of Education of Patients and Service to the Community

Recognition

2009-2015	Best Doctors Boston
2010-2014	America's Top Surgeons Consumer Council of America
2010-2015	Patient's Choice Award
2011-2014	Most Compassionate Dr. Award
2013-2015	Town of Brookline Favorite Doctor Award
2013-2015	Boston Super Doctors
2014-2016	Talk of the Town Massachusetts: Excellence in Patient Satisfaction

Report of Scholarship

Publications

Peer reviewed publications in print or other media

Research Investigations

1. Davies GC, **Mowschenson PM**, Salzman EW. Thromboxane B2 and fibrinopeptide A levels in Platelet consumption and thrombosis. Surg Forum 1978;29:471-472.

2. **Mowschenson PM**, Schonbrunn A. Leupeptin inhibits stimulated prolactin synthesis and secretion in a clonal strain of rat pituitary cells. Prog. of the 63rd Meeting of the Endocrine Society, Cincinnati Ohio .1981.

3. **Mowschenson PM**, Rosenberg S, Pallotta J, Silen W. Effect of hyperparathyroidism and hypercalcaemia on lower esophageal sphincter pressure. Am J Surgery 1982;143:36-39.

4. Kim D, Porter DH, Siegel JB, **Mowschenson PM**, Steer ML. Common bile duct biopsy with the Simpson atherectomy catheter. Am J Roentgenol 1990;154(6):1213-5.

5. Lion J, Vertrees J, Malbon A, Harrow B, Collard A, **Mowschenson PM**. The case mix of ambulatory surgery as measured by ambulatory visit groups. J Ambul Care Manage 1990;13(1):33-45.

6. Lion J, Vertrees J, Malbon A, Collard A, **Mowschenson PM**. Toward a prospective payment system for ambulatory surgery. Health Care Financ Rev 1990;11(3):79-86.

7. **Mowschenson PM**, Critchlow JA, Peppercorn MA. The ileoanal pouch operation without covering ileostomy. American Society of Gastroenterology, New Orleans. June 1991

8. **Mowschenson PM**, Critchlow JF, Rosenberg SJ, Peppercorn MA. The rectal inhibitory reflex is not required for the preservation of continence following ileoanal pouch operation. American Society of Gastroenterology, San Francisco May 1992

9. Muggia A, **Mowschenson PM**, Chopra S. Urinary ascites in the immediate postpartum period. Am J Gastroenterol 1992;87(9):1196-7.

10. **Mowschenson P**, Weinstein M. Why catheterize the bladder for laparoscopic cholecystectomy? J Laparoendosc Surg 1992;2(5):215-217.

11. **Mowschenson PM**, Critchlow JF, Rosenberg SJ, Peppercorn MA. Pouch ileoanal anastomosis without diverting ileostomy in fulminant ulcerative colitis. Annales de Chirugie 1992;46(10) International Symposium on the Pouch Anal Anastomosis. Versailles, France.

12. **Mowschenson PM**. Improving the cost effectiveness of laparoscopic cholecystectomy. J Laparoendosc Surg 1993;3(2):113-9.

13. Laparoscopically assisted intestinal resection: Preliminary results from the Harvard interhospital laparoscopic group (HILG) Accepted for S.S.A.T. May 1993

14. **Mowschenson PM**, Critchlow JF, Rosenberg SJ, Peppercorn MA. Ileoanal pouch operation without diverting ileostomy in fulminant ulcerative colitis. Gastroenterology 1993;104 (4):A749.

15. **Mowschenson PM**, Resnick RH, Parker JH, Critchlow JF. Ileoanal pouch mucosal permeability assessment using oral (99MTC) DTPA. Gastroenterology 1993;104 (4):A749.

16. **Mowschenson PM**, Critchlow JF, Rosenberg SJ, Peppercorn MA. The ileoanal pouch operation: Factors favoring continence, the avoidance of a diverting ileostomy, and small bowel conservation. Surg Gynecol Obstet 1993;177(1):17-26.

17. **Mowschenson PM**, Hodin RA, Wang HH, Upton M, Silen W. Fine needle aspiration of normal thyroid tissue may result in the misdiagnosis of follicular neoplasms. Surgery 1994;116:1006-9.

18. **Mowschenson PM**, Critchlow JF. Outcome of surgical complications following ileoanal pouch operation without diverting ileostomy. Am J Surg 1995;169:143-6.

19. Fraser JL, Jeon GH, Hodin RA, **Mowschenson PM**, Pallotta J, Wang HH. Utility of repeat fine needle aspiration in the management of thyroid nodules. Am J Clin Pathology 1995;104 (3):328-9.

20. **Mowschenson PM**, Hodin RA. Feasibility, safety, and cost savings of outpatient thyroid and parathyroid operations. Surgery 1995;118:1051-1054.

21. Saldinger PF, Matthews JB, **Mowschenson PM**, Hodin RA. Stapled laparoscopic splenectomy: Initial experience. J Am Coll Surg 1996;182(5): 459-461.

22. Greene AK, **Mowschenson PM**, Hodin RA. Is Sestamibi-guided parathyroidectomy really cost-effective? Surgery 1999;126:1036-41.

23. **Mowschenson PM**, Critchlow JA, Peppercorn MA. Ileoanal pouch operation: Long term outcome with or without diverting ileostomy. Arch Surg 2000;135(4):463-466.

24. Schoetz DJ, Hyman NH, **Mowschenson PM**, Cohen JL. Controversies in inflammatory bowel disease. Arch Surg 2003;138(4):440-6.

25.Evenson A, **Mowschenson P**, Wang H, Connolly J, Mendrinos S, Parangi S, Hasselgren PO. Hyalinizing trabecular adenoma--an uncommon thyroid tumor frequently misdiagnosed as papillary or medullary thyroid carcinoma. Am J Surg 2007;193(6):707-12.

26.O'Neal PB, Poylin V, **Mowschenson P**, Parangi S, Horowitz G, Pant P, Hasselgren PO. When initial postexcision PTH level does not fall appropriately during parathyroidectomy: What to do next? World J Surg 2009;33(8):1665-73.

27.O'Neal P, **Mowschenson P**, Connolly J, Hasselgren PO. Large parathyroid tumors have an increased risk for atypia and carcinoma. Am J Surg 2011;202:146-150.

28.Mendiratta-Lala M, Brennan DD, Brook OR, Faintuch S, **Mowschenson PM**, Sheiman RG, Goldberg SN. Efficacy of radiofrequency ablation in the treatment of small functional adrenal neoplasms. Radiology 2011;258(1):308-16.

29.Cypess AM, Doyle AN, Sass CA, Huang TL, **Mowschenson PM**, Rosen HN, Tseng YH, Palmer EL III, Kolodny GM. Quantification of human and rodent brown adipose tissue function using 99mTc-methoxyisobutylisonitrile SPECT/CT and 18F-FDG PET/CT. J Nucl Med 2013;54(11):1896-901.

30. Mehrzad R, Connolley J, Wong H, **Mowschenson P**, Hasselgren PO. Increasing incidence of papillary thyroid carcinoma of the follicular variant and decreasing incidence of follicular adenoma: co-incidence or altered criteria for diagnosis? Surgery (2016 May) 159(5):1396-406

Other peer-reviewed publications

31. Rectal Eversion Technique: A Method to Achieve Very Low Rectal Transection and Anastomosis With Particular Value in Laparoscopic Cases Poylin V, Mowschenson P, Nagle D Diseases of the Colon & Rectum. 60(12):1329-1331, December 2017.

Non-peer reviewed scientific or medical publications/materials in print or other media

Reviews:

1. **Mowschenson PM**, Silen W. Development in Hyperparathyroidism. Curr Opin Clin Oncol 1990;2(1):95-100.

2. **Mowschenson PM**. Advances in the surgery of inflammatory bowel disease. Seminars in Colon & Rectal Surgery. March 1993.

Editorials:

1. **Mowschenson PM**. Double-Stapled versus Handsewn Pouch - Does it Matter? Inflammatory Bowel Diseases 1995;1(2):169.

2. **Mowschenson PM**. Is a One Stage Pouch Too Risky? Inflammatory Bowel Diseases 1998;4(4):332.

Book chapters:

1. Glotzer DJ, **Mowschenson PM**. Chronic Ulcerative Colitis. In: Current Surgical Therapy, Fifth Edition. Cameron, ed. St. Louis: C.V. Mosby Company, 1995. pp150-159.

Books edited:

1. **Mowschenson PM**, ed. Aids to Undergraduate Surgery. 1st edition. London: Churchill Livingstone; 1978.

2. **Mowschenson PM**, ed. Aids to Undergraduate Surgery. 2nd edition. London: Churchill Livingstone; 1982.

3. **Mowschenson PM**, ed. Aids to Undergraduate Surgery. German language edition. London: Churchill Livingstone; 1984.

4. **Mowschenson PM**, ed. Aids to Undergraduate Surgery. 3rd edition. London: Churchill Livingstone; 1989.

5. **Mowschenson PM**, ed. Aids to Undergraduate Surgery. 4th edition. London: Churchill Livingstone; 1994.

Narrative Report

I joined the staff at Beth Israel Hospital in 1981 after completing by surgical training and have remained on staff through the merger when Beth Israel Hospital became Beth Israel Deaconess Medical Center.

While certified in General Surgery, my particular areas of interest and expertise evolved into surgery for inflammatory bowel disease, and thyroid and parathyroid surgery. These are the main areas of my publications. I have given numerous lectures on both these topics as detailed in my CV.

I have been an active teacher on the clinical side all these years, providing operating room and office teaching for residents at all levels in addition to HMS students. I have a very busy clinical practice, and residents who rotate on my service end up with greatly above average experience in thyroid and parathyroid surgery.

I have never had any basic science responsibility but have participated in published research along with basic scientists. I continue to be active in clinical research in the areas or surgery for inflammatory bowel disease and endocrine surgery.

I was president of the Affiliated Physicians Group from1983 to 2019 which is a major component of BIDCO along with HMFP (Harvard Medical Faculty Practice), and involved in monthly board meetings of BIDCO. For many years I was active in the Crohn's and Colitis Foundation.

AFFIDAVIT OF JUDITH CLIMENSON, RN, CCRN-CMC, CNRN-SCRN

PERSONALLY APPEARS before the undersigned authority, duly authorized to administer oaths, comes Judith Climenson, RN, who after first being duly sworn, states as follows:

Introduction and Limited Purpose of Affidavit

1. I have been asked to provide this affidavit for the limited purpose of Georgia statute OCGA § 9-11-9.1.

2. This affidavit states my views of the matters discussed below — views I formed from my review of the evidence. However, Plaintiff's counsel did the typing and supplied the snapshots from medical records, the Bates numbers, the legalese, the formatting, etc.

3. This affidavit does not attempt to state or summarize all my opinions. This affidavit addresses specific matters that Plaintiff's counsel have asked me to examine for purposes of testimony at trial. I have not attempted to identify every person who may have violated a standard of care. Nor have I attempted to identify every standard of care that a particular person violated. If additional information becomes available later, or if I am asked to address other matters, then of course my opinions may change.

4. As to the matters this affidavit addresses, I have tried to give a reasonably detailed explanation of my views, but I have not necessarily attempted an exhaustive discussion. In deposition or trial testimony, I may elaborate with additional details. In particular, while I cite evidence from the medical records for various facts, I do not necessarily cite *all* the evidence for a given point.

5. I use the term "standard of care" to refer to that degree of care and skill ordinarily exercised by members of the nursing profession generally under the same

or similar circumstances and like surrounding conditions as pertained to the medical providers I discuss here.

6. I hold all the opinions expressed below to a reasonable degree of nursing certainty — that is, more likely than not.

Topic & Opinions

7. This affidavit concerns medical services provided to Kang Moua in August 2019.

8. This affidavit concerns the standard of care for nurses responding to a patient in respiratory distress because of an evident post-operative hematoma in the neck, and more specifically, the standard for carrying out instructions received by telephone from an on-call surgeon, or relaying those instructions to a physician in the room with the patient.

9. It appears from the records that the on-call surgeon instructed a member of the nursing staff that the sutures on Mrs. Moua's neck must be removed.

10. The standard of care for the nursing staff required them either (a) to carry out the surgeon's instructions or (b) to relay those instructions to the physicians in the room attending to the patient.

11. It appears from the records that the nursing staff did not cut the sutures.

12. It further appears from the records that the nursing staff did not relay the surgeon's instructions to the resident, Dr. Waqas Ahmad, or to the ER physician, Dr. Johnson.

13. The nurses responding to Kang Moua's Code Blue violated their standards of care by failing to cut the sutures on the surgeon's instruction or at least to relay those instructions to the two physicians in the room with Mrs. Moua.

14. These were gross violations of the standard of care.

Qualifications

15. I am more than 18 years old, suffer from no legal disabilities, and give this affidavit based upon my own personal knowledge and belief.

16. I do not recite my full qualifications here. I recite them only to the extent necessary to establish my qualifications for purposes of expert testimony under OCGA 24-7-702.

17. However, my Curriculum Vitae is attached hereto as Exhibit "A." My CV provides further detail about my qualifications. I incorporate and rely on that additional information here.

18. The acts or omissions at issue here occurred in August 2019.

19. I am qualified to provide expert testimony pursuant to OCGA 24-7-702. That is:

a. In August 2019, I was licensed by an appropriate regulatory agency to practice my profession in the state in which I was practicing or teaching in the profession.

   Specifically, I was licensed by the States of Arizona, California, and Georgia to practice as a registered nurse. In August 2019 I was practicing as a registered nurse in Arizona.

b. In August 2019, I had actual professional knowledge and experience in the area of practice or specialty which my opinions relate to — specifically, the areas of:

   - Removing sutures/staples.
   - Carrying out instructions from a physician.
   - Relaying instructions from an on-call physician to an attending physician.

c. I had this knowledge and experience as the result of having been regularly engaged in the active practice of the foregoing areas of specialty of my profession for at least three of the five years prior to August 2019, with sufficient frequency to establish an appropriate level of knowledge of the matter my opinions address.

Specifically, I am a registered nurse and for many years have practiced as a critical care nurse in a hospital setting.

Evidence Reviewed

20. I have reviewed Kang Moua's medical records from St. Mary's Health Care System.

Discussion and Factual Basis for Opinions

21. Moua Kang was a 38 year old otherwise healthy woman who underwent total thyroidectomy with neck dissection by Dr. Blake Kimbrell on 8/9/2019. (SMH 31-34.)

DATE OF OPERATION: 08/09/2019

PREOPERATIVE DIAGNOSIS:
T3N1bMx papillary thyroid carcinoma of the left thyroid.

POSTOPERATIVE DIAGNOSIS:
T3N1bMx papillary thyroid carcinoma of the left thyroid.

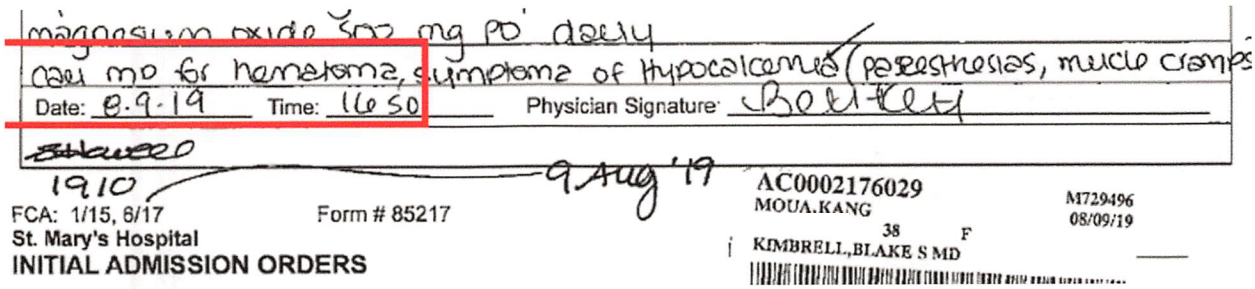
PROCEDURE PERFORMED:
1. Total thyroidectomy with recurrent laryngeal nerve monitoring.
2. Left selective neck dissection levels 2 through 4.
3. Left central neck dissection.

SURGEON:
Blake Kimbrell, M.D.

22. Following an uncomplicated operation, Moua Kang was taken to the PACU where she remained stable, and then transferred to a regular floor to recover. (SMH 34.)

nylon was used at the skin followed by bacitracin. The patient tolerated the procedure well and was given back to anesthesia, awakened, extubated, and taken to the PACU in stable condition.

23. The admission orders for the surgery unit instructed, "Call MD for hematoma." (SMH 60.)


magnesium oxide 500 mg PO daily
call MD for hematoma, symptoms of hypocalcemia (paresthesias, muscle cramps
Date: 8-9-19 Time: 1650 Physician Signature:
1910 9 Aug '19
FCA: 1/15, 8/17 Form # 85217
St. Mary's Hospital
INITIAL ADMISSION ORDERS
AC0002176029
MOUA.KANG
38 F
KIMBRELL,BLAKE S MD
M729496
08/09/19

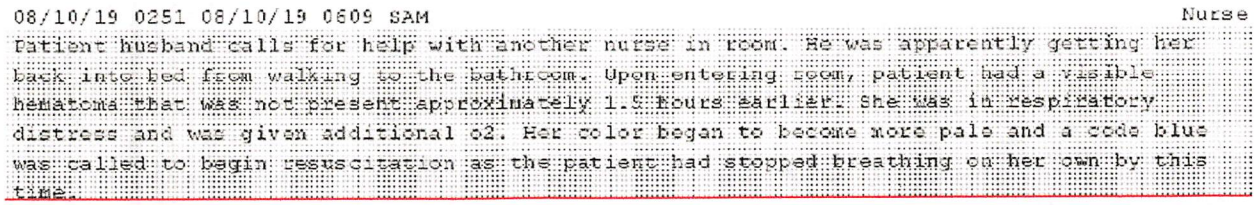
24. At 0245 on 8/10/19, Moua Kang was helped to the bathroom by her husband and on returning she complained of swelling in her left neck. Her husband alerted nursing. (SMH 14, 500.)

This is a 38-year-old Asian female the past medical history of papillary thyroid cancer came in for thyroidectomy that was performed yesterday on 8/9/2018. After surgery, the patient was reported to be stable and doing well. Around 2:45 AM on 8/10/she ambulated to the bathroom 2019 and after she laid down she was found by the nurse to having stridorous. CODE BLUE was called at 2:51 AM. CODE BLUE was called at 2:51 AM. Patient was found to be cyanotic and chest compression immediately began at 2:52 AM. During my encounter, there was noted hematoma localized to the left anterior neck region with staples intact. Manual chest compression was substituted via Lucas device compression. Overall patient received 4 doses of IV epinephrine and patient was in PEA. ER physician Dr. Johnson attempted to place an endotracheal tube but due to the neck hematoma he was unable to secure her airway. Dr. Norris the ENT physician came in and instructed to remove the staples with creating an incision to prepare for placement for tracheostomy. Blood was being suctioned and then patient was in process of being transferred to the OR. Prior to leaving the room patient still did not have ROSC and was still receiving LUCAS device compressions. ET tube was placed through the incised trach site prior to leaving the room. While receiving compressions in the OR, the defibrillator device showed her to be in V. fib briefly. Patient received a shock

Occurred Date	Occurred Time	Recorded Date	Recorded Time	By	Notes: All Categories Category
08/10/19	0251	08/10/19	0609	SAM	Nurse

Patient husband calls for help with another nurse in room. He was apparently getting her back into bed from walking to the bathroom. Upon entering room, patient had a visible hematoma that was not present approximately 1.5 hours earlier. She was in respiratory distress and was given additional o2. Her color began to become more pale and a code blue was called to begin resuscitation as the patient had stopped breathing on her own by this time.

25. According to a note by Nurse Steven A. Moon, at 0251 hours, "Upon entering room, patient had a visible hematoma that was not present approximately 1.5 hours earlier. She was in respiratory distress...."


08/10/19 0251 08/10/19 0609 SAM Nurse
Patient husband calls for help with another nurse in room. He was apparently getting her back into bed from walking to the bathroom. Upon entering room, patient had a visible hematoma that was not present approximately 1.5 Hours earlier. She was in respiratory distress and was given additional o2. Her color began to become more pale and a code blue was called to begin resuscitation as the patient had stopped breathing on her own by this time.

26. A Code Blue was called.

27. According to a note by Dr. Norris of ENT who was on call, the nursing staff called him at 0256 hours. He drove into the hospital and according to his note ordered the neck sutures to be removed. (SMH 14, 215, 216, 500.)

[*See* screenshots above.]

I was called by the St. Mary's fifth surgical floor at 2:56 a.m. regarding the patient. The personnel reported that the patient was undergoing a code and that the code team was unable to establish an airway. I made a recommendation to cut the patient's thyroidectomy sutures to remove her drains and to call both Anesthesia and General Surgery if General Surgery was in house. I proceed immediately to the bedside. En route to the hospital, I called Dr. Blake Kimbrell to notify him of the events. Upon arrival to the bedside, I asked for a tracheostomy tray. I immediately removed the anterior cervical sutures which had not been cut and evacuated the hematoma of the anterior cervical area. The airway was deviated into the right neck but was not compressed as I could tell from palpation. I cut the sutures of the strap musculature and established an airway with a 6.0 cuffed endotracheal tube. There was a hematoma in the left neck and pressure was applied to prevent any further bleeding. The code was ongoing and Anesthesia was then at the bedside as was Dr. Kimbrell. We proceeded down to the operating room for surgery.

28. It is within the scope of practice of a nurse to remove sutures — both as a general matter and in the circumstances affecting Kang Moua.

29. If the nursing staff were not competent to remove sutures for a patient in Kang's circumstances, then they should not have been given, and should not have taken, responsibility for treating her after a thyroidectomy in which a hematoma in her neck was foreseeable.

30. Upon receiving Dr. Norris' instructions to remove the sutures for a patient whose airway was being cut off by a rapidly expanding hematoma, the nursing staff should have immediately removed the sutures. Failure to do so violated the standard of care.

31. If a physician was in Kang's room when Dr. Norris gave the instruction to remove the sutures, then the nursing staff should have immediately relayed Dr. Norris' instruction to the in-room physician. Failure to do so violated the standard of care.

32. According to a History of Present Illness note by Resident, Dr. Waqas Ahmad, Dr. Johnson, an emergency room physician was called and attempted to intubate the patient. He did not remove the sutures as requested by Dr. Norris and he was unable to perform the intubation. The patient then went into cardiopulmonary arrest. (SMH 14, 216.)

> This is a 38-year-old Asian female the past medical history of papillary thyroid cancer came in for thyroidectomy that was performed yesterday on 8/9/2018. After surgery, the patient was reported to be stable and doing well. Around 2:45 AM on 8/10/she ambulated to the bathroom 2019 and after she laid down she was found by the nurse to having stridorous. CODE BLUE was called at 2:51 AM. CODE BLUE was called at 2:51 AM. Patient was found to be cyanotic and chest compression immediately began at 2:52 AM. During my encounter, there was noted hematoma localized to the left anterior neck region with staples intact. Manual chest compression was substituted via Lucas device compression. Overall patient received 4 doses of IV epinephrine and patient was in PEA. ER physician Dr. Johnson attempted to place an endotracheal tube but due to the neck hematoma he was unable to secure her airway. Dr. Norris the ENT physician came in and instructed to remove the staples with creating an incision to prepare for placement for tracheostomy. Blood was being suctioned and then patient was in process of being transferred to the OR. Prior to leaving the room patient still did not have ROSC and was still receiving LUCAS device

> Brief progress note was entered (just as patient was transferred from the OR to her ICU room). Since, I have met with the family (at the appropriate time, discussed with Troung, her husband), discussed the event with nursing, and performed a chart review to better understand the timeline of events. Her husband reports she was doing well throughout the evening. He recalls RN checking on her between 1 and 2 am. He reports he went back to sleep but everything appeared to be well. Just before he called for nursing, he took Mrs. Moua to the restroom at her request. He confirmed to me at that time and throughout her restroom trip there were no complaints of increased pain, difficulty breathing or swallowing. In fact, she even requested to brush her teeth prior to getting back in bed (he wouldnt let her and told her she needed to rest). He reports she was "fine" even as she sat back down. Then, she "leaned her head back" reported a "pop" and started to complain of pain in the neck. He noted swelling at that time and called nursing immediately. Floor nursing called the rapid response and code. Unfortunately, Dr. Norris' request of cutting sutures in the neck weren't done when he had arrived. Oral intubation could not be obtained. He was able to immediately evacuate the clot after cutting sutures and a trach was quickly performed (her airway was easily palpable following the removal of her cancer). The remainder of the details are documented in Meditech.

33. Manual chest compression was employed at 0251 according to the Code Blue Flowsheet. (SMH 496.)

Time	Breathing		Pulse		BP
	Spontaneous	Assisted (✓)	Spontaneous	Assisted (✓)	
0251		✓		✓	

34. Dr. Norris arrived on the scene, promptly removed the sutures which allowed the hematoma to decompress, and was then able to control the patient's airway with an emergency tracheotomy. Intubation through the emergency tracheotomy site was recorded as 0310 with a 6.5 tube. (SMH 13-14, 48, 215-16, 500.)

[*See* screenshots above.]

CODE BLUE was called at 2:51 AM. Patient was found to be cyanotic and chest compression immediately began at 2:52 AM. During my encounter, there was noted hematoma localized to the left anterior neck region with staples intact. Manual chest compression was substituted via Lucas device compression. Overall patient received 4 doses of IV epinephrine and patient was in PEA. ER physician Dr. Johnson attempted to place an endotracheal tube but due to the neck hematoma he was unable to secure her airway. Dr. North the ENT physician came in and instructed to remove the staples with creating an incision to prepare for placement for tracheostomy. Blood was being suctioned and then patient was in process of being transferred to the OR. Prior to leaving the room patient still did not have ROSC and was still receiving LUCAS device compressions. ET tube was placed through the incised trach site prior to leaving the room

35. The code flowsheet lists Teonna Greggs RN as the recorder, Christie as the ICU code team nurse, Heather Hust RN as the ER nurse, and Tori Hall RRT as the respiratory therapist. (SMH 496.)

Signatures

Recorder Teonna Greggs, RN ID# 425330
ICU/Code Team Nurse Christie ID#
Emergency Dept. Nurse Heather Hust, RN ID#
Respiratory Therapist Tori Hall, RRT ID#
Physician Signature
Other Title

36. There is then a follow up note regarding the Code Blue signed by Waqas Ahmad MD, a resident, which mentions 0245 as the time the patient began to have significant breathing problems. (SMH 48.)

The nurse reported patient clinically was doing well prior to the CODE BLUE. Apparently she was ambulating to the restroom around 2 45 AM and when she layed down patient respiratory status worsened as the nursed noted her to have stridor. RAPID RESPONSE was called but this was escalated immediately to CODE BLUE.

37. There is a handwritten progress note by Dr. Norris and/or Dr. Kimbrell at 0451 and then 055? stating that he was first called at 0256 and informed of the code and the uncontrolled airway. (SMH 264.)

8/10/19	ENT
0451	See full note dictated.
	I was called at 0256 by the 5th floor who reported that Ms. Kang was in a code situation and did not have an airway. I came immediately and was able to establish the airway by removing the anterior cervical sutures, the sutures to the strap musculature, and by creating a tracheostomy and placement of a 6.0 cuffed ETT.
	While continuing code management, we proceeded to the OR & anesthesia and pulses were reestablished and a wash out of the neck performed. There was bleeding from the left superior thyroid artery despite a surgical clip in place in good position. There was some oozing from clips on the left internal jugular vein which was ligated. The tracheostomy was formalized and a 6 DCT trach placed. The patient was transferred to the ICU.
8/10/19	I have been present since 0310 helping care for Ms. Mona. When I arrived
055	the airway had been established. I immediately went to the OR & Dr. Norris to examine her neck for bleeding. Please see my dictation for details. All vessels were identified and clipped. Once clot was removed the left superior thyroid artery clip was moved slightly and the artery was bleeding. I have updated the family and will continue to be here for them. Following closely.

38. Moua Kang was taken emergently to the OR where Dr. Kimbrell and Dr. Norris completed evacuation of the neck hematoma and identified some bleeding sites which were controlled. (SMH 37.)

DATE OF OPERATION: 08/10/2019

SURGEON:
Blake Kimbrell, MD

CO-SURGEON:
Byron Norris, MD

ANESTHESIA:
General via tracheostomy placement.

OPERATION PERFORMED:
1. Washout of left neck hematoma.
2. Revision of tracheostomy tube placement.
3. Control of left neck bleeding.

PREOPERATIVE DIAGNOSES:
1. Cervical hematoma.
2. Respiratory distress.
3. Bleeding of the left neck.

39. Moua Kang was then transferred to the ICU. She suffered anoxic brain damage and died. (SMH 25.)

Although the patient's temperature was at the lower end of the range reported for valid brain death examination, I believe that due to the very dilute urine output and the patient's exam, the patient's status is worrisome for being consistent with brain death. We will warm the patient and I have consulted both Dr. Edry and also spoken with Dr. Bhatt regarding making the patient more normothermic prior to formal brain death confirmatory examination. However, 33 degrees Celsius has generally been reported as acceptable in the range of the peer-reviewed literature. In addition to that, the patient's CT scanning certainly is a very impressive in terms of the progression of cerebral edema. I have discussed the findings and full with multiple family members and they were understandably very upset by this development. I informed them that independent physicians would be coming in to examine Ms. Moua and also provide further confirmation of her neurological status. I also discussed the findings with both Dr. Norris and Dr. Kimbrell.

40. There is an additional progress note by Dr. Kimbrell at 0846 on 8/10/19 in which he states that Dr. Norris' request of cutting sutures had not been carried out when he arrived. (SMH 216.)

[*See* screenshot above.]

41. There is also a progress note by Dr. Norris at 0554 on 9/10/19. He states that he was called at 2:56 AM and that he recommended removing the neck sutures. He states that upon opening the neck the trachea was deviated to the right 'but not compressed.' He was able to control the airway. (SMH 215.)

[*See* screenshot above.]

Miscellaneous

42. To repeat, this affidavit does not exhaust my current opinions and of course does not reflect any opinions I may form later.

43. Again, I hold each opinion expressed in this affidavit to a reasonable degree of medical probability or certainty; that is, more likely than not.

Judith Climenson, RN

SWORN TO AND SUBSCRIBED before me

April 8th, 2020

NOTARY PUBLIC

Kevin Lawler
Notary Public
Maricopa County, Arizona
My Comm. Expires 02-22-2023
Commission No. 562003

My Commission Expires: 02-22-2023

Judith Climenson RN, CCRN-CMC, CNRN-SCRN

6633 E. Juniper Ave
Scottsdale, AZ 85254
Phone: 805 448-5835

E Mail: jclimenson@cox.net

Summary of Qualifications

38 YEARS EXPERIENCE IN ACUTE AND CRITICAL CARE. 18 YEARS EXPERIENCE AS AN INDEPENDENT LEGAL NURSE CONSULTANT FOR CHART REVIEW FOR MERIT FOR MEDICAL MALPRACTICE, AND EXPERT WITNESSING FOR NURSING STANDARD OF CARE.

Professional Membership

AMERICAN ASSOCIATION OF CRITICAL CARE NURSES; AMERICAN ASSOCIATION OF LEGAL NURSE CONSULTANTS; AMERICAN NURSING ASSOCIATION; AMERICAN ASSOCIATION OF NEUROSCIENCE NURSES

Education

ASSOCIATE DEGREE IN NURSING, COLLEGE OF MARIN, 1980, KENTFIELD, CA.; CCRN CERTIFIED SINCE 1982; CARDIAC MEDICINE CERTIFIED SINCE 2006; NEURO CERTIFIED 2012; STROKE CERTIFIED 2016; ACLS/BLS CERTIFIED; IABP CERTIFIED
REGISTERED NURSE LICENSE: ARIZONA, CALIFORNIA AND GEORGIA

Work experience

STAFF RN AT SCOTTSDALE MEDICAL CENTER OSBORN IN THE SCU [SPECIAL CARE UNIT] JULY 2014- PRESENT

RN III , SAVANNAH MEMORIAL HEALTH UNIVERSITY MEDICAL CENTER, NEURO & CARDIOVASCULAR INTENSIVE CARE UNIT, APRIL 2009 TO JUNE 2014

STAFF RN, SANTA BARBARA COTTAGE HOSPITAL, CLINICAL RESOURCE NURSE FOR ICU AND CCU, AUGUST 2003-APRIL 2009

CONTRACTED CRITICAL CARE RN, MEDITECH HEALTH SERVICES, VENTURA, CA, ASSIGNMENTS IN ICU, CCU, ER AND TELEMETRY, 2000-2003

STAFF RN- CHARGE NURSE FOR CVICU AND TELEMETRY, SCOTTSDALE HEALTHCARE SHEA, SCOTTSDALE, AZ, 1991-2000

STAFF RN- CHARGE NURSE FOR CVICU AND TELEMETRY, PHOENIX, John C. Lincoln Hospital, AZ, 1985-1998

CHARGE NURSE, SONOMA VALLEY HOSPITAL, CRITICAL CARE UNIT, SONOMA, CA, 1980-1985

Exhibit A